Region 2/5 TRICARE Prime Remote Enrollment/Transfer/Change Form

Please refer to the instructions located on the reverse side of the form.

For enrollments or changes to Primary Care Managers (PCM), please call (800) 931-9501 in the Mid-Atlantic Region 2 or (800) 941-4501 in the Heartland Region 5 or visit the HMHS website at www.humana-military.com for guidance on PCM selection in your area. Humana Military Healthcare Services, Inc. will assign a PCM if your first or second choice cannot be honored.

Check appropriate box for all that apply:

TRICARE

- ❑ **Enrollment** – Complete Active Duty Service Member (ADSM) Information section, Family Member Information section if applicable and Acknowledgement/Signature section.
- ❑ **Address Change** – Complete #1-9 in ADSM Information section and Acknowledgement/Signature section. **If change is for a family member for a different address**, complete #1-2 of ADSM Information section, Family Member Information section and Acknowledgement/Signature section. **Effective Date of Move** _____
- ❑ **Transfer/Portability** – Complete ADSM Information section, Family Member Information section if applicable and Acknowledgement/Signature section if applicable.
- ❑ **Disenrollment** – Complete #1-2 of ADSM Information section, #15 of the Disenrollment section and #16 of the Acknowledgement/Signature section. Also complete Family Member Information section if applicable.
- ❑ **Primary Care Manager Change** – Complete #1-5 in ADSM Information section and Acknowledgement/Signature section. **If change is for a family member**, complete #1-2 of ADSM Information section, Family Member Information section and Acknowledgement/Signature section. **Reason for Change** _____

Active Duty Service Member (ADSM) Information (REQUIRED)

1. ADSM Name Last First MI

2. ADSM Social Security Number | 3. Branch of Service

4. ADSM's 1st Choice of PCM (Refer to the TRICARE toll-free number, our website or call your regional toll-free number for assistance, number listed on back)

5. ADSM's 2nd Choice of PCM (2nd choice will be honored if your 1st choice is full)

6. Residential Address Street Apt. # City County State Zip Code Phone ( )

7. Physical Work Address Street Apt.# City County State Zip Code Phone ( )

8. Unit of Assignment Address Street Apt.# City County State Zip Code Phone ( )

9. Unit Identification Code | 10. Have you completed the other health insurance form, if applicable? ❑ Yes ❑ No

Family Member Information

11. Name Last First MI | Social Security Number

Street Address or P.O. Box Apt. # City County State Zip Code | Phone ( )

Family Member's 1st Choice – PCM (Civilian Physician) List PCM name & complete address

Family Member's 2nd Choice – PCM (Civilian Physician) List PCM name & complete address

12. Name Last First MI | Social Security Number

Street Address or P.O. Box Apt. # City County State Zip Code | Phone ( )

Family Member's 1st Choice – PCM (Civilian Physician) List PCM name & complete address

Family Member's 2nd Choice – PCM (Civilian Physician) List PCM name & complete address

13. Name Last First MI | Social Security Number

Street Address or P.O. Box Apt. # City County State Zip Code | Phone ( )

Family Member's 1st Choice – PCM (Civilian Physician) List PCM name & complete address

Family Member's 2nd Choice – PCM (Civilian Physician) List PCM name & complete address

14. Name Last First MI | Social Security Number

Street Address or P.O. Box Apt. # City County State Zip Code | Phone ( )

Family Member's 1st Choice – PCM (Civilian Physician) List PCM name & complete address

Family Member's 2nd Choice – PCM (Civilian Physician) List PCM name & complete address

Disenrollments

15. Check reason for disenrollment

❑ Moved to non-remote location Address _____

❑ Other _____

Acknowledgement/Signature

16. **I have read the information on benefits and restrictions of the TRICARE Prime Remote program provided me.** I understand the restrictions as stated or explained to me and hereby apply for enrollment. **If I decide to obtain care which has not been coordinated by my PCM and authorized by the Health Care Finder, or seek services from a non-TRICARE Prime Remote provider, I understand that TRICARE Prime Remote coverage will not apply and I will be responsible for payment under the Point of Service option for all services received.** I understand I must remain enrolled in TRICARE Prime Remote for 12 consecutive months. I understand that my entitlement to TRICARE benefits will be confirmed through the Defense Enrollment Eligibility Reporting System (DEERS). I authorize the Plan to examine, disclose and copy records of any physician, hospital or provider when necessary for proper payment of benefits for all enrollees listed on this document. I hereby certify that the information provided on this document is true and complete. I agree to abide by the provisions of membership. I must disenroll from TRICARE Prime Remote when I am no longer eligible or move from areas where TRICARE Prime Remote is offered. The Plan will not discriminate, or have the effect of discriminating, against any beneficiaries on the basis of health status, age, race, sex, family size, sponsor status or sponsor rank. I understand that there is a possibility that some medical specialty diagnosis or treatment may require travel to health care providers which exceed stated access standards. (PCMs will be available within a 30 minute drive from your home and specialists within a one hour drive). **SIGNATURE IS REQUIRED TO COMPLETE ENROLLMENT FORM.** Please review the Agency Disclosure and The Privacy Act before signing.

_____ _____ _____

Signature **If other than ADSM, Relationship to ADSM** **Today's Date**

AUTHORITY: 5 U.S.C 552 (a) and 10 Chapter 55, CHAMPUS PRINCIPAL PURPOSES: Enrollment in the TRICARE Prime Remote program. ROUTINE USES: Verify eligibility and produce identification cards. DISCLOSURE IS VOLUNTARY. Failure to provide the information could result in denial of reimbursement under the CHAMPUS program.

WHEN COMPLETE, MAIL (WITH HEAR FORM IF APPLICABLE) TO:

Humana Military Healthcare Services, Inc., P.O. Box 740072, Louisville, KY 40201-7472

PLEASE RETAIN YELLOW COPY FOR YOUR RECORDS.

Instructions for Region 2/5 TRICARE Prime Remote Enrollment/Transfer/Change Form

Thank you for choosing TRICARE Prime Remote. Please print all information clearly in ink and sign the form. **Use this form to enroll in, disenroll from, or change information for TRICARE Prime Remote.** Once complete, sign and send the form to the address indicated at the bottom of the form. Keep the yellow copy for your records. **Your application will be delayed if the form is incomplete, unsigned or does not match the DEERS information on file.** If you are unsure of how to answer a question, please call our toll-free number. In Mid-Atlantic Region 2 call (800) 931-9501 and in Heartland Region 5 call (800) 941-4501. Our Beneficiary Service Representatives will be happy to assist you. Mid-Atlantic Region 2 includes North Carolina and most of Virginia (excluding the Washington DC metropolitan area). Heartland Region 5 includes Michigan, Wisconsin, Illinois, Indiana, Kentucky, Ohio, most of West Virginia, the St. Louis area of Missouri, the Ft. Campbell area of Tennessee, and portions of eastern Iowa adjacent to Rock Island (IL) Arsenal.

IF ENROLLING: Effective dates will be effective the first day of the following month if this form is received by the 20th of the current month and all information is complete. **If transferring**, enrollment is effective on the date a complete form is received. **YOUR COMPLETED FORM WILL BE PROCESSED UPON RECEIPT. THE YELLOW COPY SHOULD BE RETAINED AS PROOF OF INTENT TO ENROLL OR TRANSFER. ENROLLMENT IS SUBJECT TO ELIGIBILITY, PCM ASSIGNMENT AND ALL OTHER TRICARE REGULATIONS. UPON COMPLETION OF THE ENROLLMENT PROCESS, A PRIME REMOTE IDENTIFICATION CARD WILL BE MAILED TO YOU AND EACH ELIGIBLE FAMILY MEMBER. THE EFFECTIVE DATE OF MEMBERSHIP WILL BE INDICATED ON EACH CARD.**

SELECTION BOX SECTION:
Check Appropriate Box for **All** that apply, then complete form information as indicated with each selection.
If selecting Address Change, supply Effective Date of Move.
If selecting Primary Care Manager Change, supply Reason for Change.

ACTIVE DUTY SERVICE MEMBER (ADSM) INFORMATION SECTION:
1. ADSM's Name - Last Name, First Name, Middle Initial
2. ADSM's Social Security Number
3. ADSM's Branch of Service
4. State ADSM's First Choice for a PCM*
5. State ADSM's Second Choice for a PCM*
6. List ADSM's Residential Address and Phone Number
7. List ADSM's Physical Work Address and Phone Number
8. List ADSM's Unit of Assignment Address and Phone Number
9. List ADSM's Unit Identification Code
10. Have you completed the other health insurance form, if applicable? Check the appropriate box.

*A TRICARE-authorized provider may be located by **visiting the HMHS website at www.humana-military.com**, or by calling **(800) 931-9501 in the Mid-Atlantic Region 2 or (800) 941-4501 in the Heartland Region 5** for guidance on Primary Care Manager (PCM) selection in your area. Humana Military Healthcare Services, Inc. will assign a PCM if your first or second choice cannot be honored, or if you do not choose a PCM, we will provide one based upon your residence address, if possible. If there is not one close to your residence, you will be enrolled with an "unassigned PCM" and will be able to use any TRICARE-authorized provider.

FAMILY MEMBER INFORMATION SECTION:
11.-14. List information for all family members who are enrolling in the TRICARE Prime Remote program.
Please state two PCM choices for each Prime Remote member. HMHS will assign a PCM if your first or second choice cannot be honored. If enrolling more than four (4) family members, please use a second enrollment form. Indicate sponsor's name and Social Security Number at the top of the second form.

DISENROLLMENT SECTION:
15. State ADSM's Reason for Disenrolling - Check Appropriate Box. If other, please specify reason.

ACKNOWLEDGEMENT/SIGNATURE SECTION:
16. Read the acknowledgment. Sign and date form and indicate relationship to sponsor if other than ADSM.

AGENCY DISCLOSURE STATEMENT: Public reporting of this collection of information is estimated to average 15 minutes per application, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data need, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to the Department of Defense, to Washington Headquarters Services, Directorate of Information Operations and Reports, 1216 Jefferson Davis Highway, Suite 1204, Arlington, VA 92202-4802; and the Office of Management and Budget, Paperwork Reduction Project 0720-0008, Washington DC 20508. PLEASE DO NOT RETURN YOUR ENROLLMENT FORM TO EITHER OF THESE ADDRESSES, SEND YOUR FORM TO THE ADDRESS SHOWN ON THE FORM.

PRIVACY ACT STATEMENT: (1) 44 USC 8101; 10 USC 1079 AND 1086, 88 USC 4318; EO 9397. (2) Purpose: To evaluate for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (82 CFR, Part 199.17). (3) Uses: Information from application forms and related documents may be given to the Department of Health and Human Services, and / or the Department of Transportation consistent with their statutory administrative responsibilities under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); to the Department of Justice for representation of the Secretary of Defense in civil actions; and to congressional Offices in response to inquiries made in the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program. (4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.